Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST, LLC
PO BOX 890008
HOUSTON TEXAS 77289

DWC Claim #: 08304827
Injured Employee: OCTAVIO CARRASCO
Date of Injury: 06/01/08
Employer Name: BORDER STEEL INC
Insurance Carrier #: 000756005077WC01

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

August 15, 2011

MFDR Tracking Number

M4-11-4750-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HealthTrust does not have a contract with Universal Smart Comp granting Universal the rights to audit our multi-disciplinary chronic pain management program. This is incorrect and has been verified directly with Universal Smart Corp. Our problem is that no one at Gallagher Bassett will make a contact with Universal and verify this and so they just keep rejecting the claims as not their responsibility."

Amount in Dispute: $6,240.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
9/15/10, 9/17/10, 9/21/10, 10/18/10, 10/19/10, 10/20/10, 10/22/10, 10/25/10, 10/26/10, 10/27/10, 10/29/10, 11/2/10	Chronic Pain Management	$6,240.00	$6,240.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Per 28 Texas Administrative Code §133.4 sets out the procedures for Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks.

3. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for Workers' Compensation Specific Services.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 12, 2010 for disputed dates of service September 15, 2010, September 21, 2010.
   - 12 – Payment adjusted due to a submission billing error. Additional information is supplied using the remittance advice remarks codes.
   - 12 – This line was included in the reconsideration of the previously reviewed bill.
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec

   Explanation of benefits dated December 13, 2010 for disputed date of service September 21, 2010.
   - 12 – Payment adjusted due to a submission billing error. Additional information is supplied using the remittance advice remarks code.
   - BL – This bill is a reconsideration of a previously reviewed bill

   Explanation of benefits dated March 2, 2011 for disputed date of service October 19, 2010.
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec

   Explanation of benefits dated April 14, 2011 for disputed dates of service September 17, 2010, October 18, 2010.
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec

   Explanation of benefits dated April 14, 2011 for disputed date of service September 21, 2010
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec

Issues

1. Did the requestor have a contractual arrangement with the insurance carrier for the dates of service in dispute?
2. Did the requestor obtain preauthorization of the chronic pain management program as required per 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement per 28 Texas Administrative Code §134.204?

Findings

1. Per 28 Texas Administrative Code §133.4 Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks, failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption in a Division enforcement action and in a medical fee dispute that the health care provider did not receive the notification. Therefore the disputed charges will be reviewed per 28 Texas Administrative Code §134.204.
2. 28 Texas Administrative Code §134.600, requires preauthorization for chronic pain management programs. The requestor obtained preauthorization for 10 visits of chronic pain management to be rendered August 19, 2010 through October 19, 2010. The requestor obtained preauthorization for an additional 10 visits of chronic pain management to be rendered October 8, 2010 through December 8, 2010.

3. Review of the CMS-1500's submitted by the requestor indicates that the provider billed CPT code 97799-CP. Per 28 Texas Administrative Code §134.204(h)(5)(A) Chronic Pain Management "shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier." Review of the CMS-1500's submitted by the requestor indicates that the provider billed CPT code 97799-CP. No CA modifier was appended to identify the program as a CARF accredited program. 28 Texas Administrative Code

§134.204 (h)(5)(B) states reimbursement shall be $125 per hour. Per Texas Administrative Code §134.204(h)(1)(B) for non-CARF accredited programs, The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR. The requestor is therefore entitled to $100 per hour for a non-CARF accredited program. The requestor billed eight hours per session as indicated on the CMS-1500 for each disputed date of service, for a total reimbursement amount of $9,600. The insurance carrier paid $3,360. Therefore, the requestor is entitled to an additional payment of $6,240.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $6,240.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,240.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Greg Arendt	
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.